PRINTED: 04/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO IDENTIFICATION NUMBER:  A. BUILDING		LE CONSTRUCTION	(X3) DATE SUF COMPLET		
		15K002	B. WIN				
NAME OF PR	ROVIDER OR SUPPLIER	13002		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	01/1	2/2012
SUNSHINI	E HOME ASSISTANCE S	ERVICES			2 W WAYNE ST ORT WAYNE, IN 46802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
		alth federal recertification artial extended survey.					
	Survey dates: Januar	y 9-12, 2012					
	Faciliy #: 005869						
	Medicaid #: 10026566	60A					
	Surveyor: Miriam Ber	nnett RN, PHNS					
	Census: 57						
		e Elder, MSN, BSN, RN v 19, 2012					
	This survey was mod 3/14/12. je	ified as the result of an IDR					
G 158	484.18 ACCEPTANC MED SUPER	E OF PATIENTS, POC,	G	158			3/2/12
		plan of care established wed by a doctor of medicine, ric medicine.					
	Based on clinical rec the agency failed to e notification of the hea when blood pressure parameters as ordere	not met as evidenced by: ord review and interview, ensure visits were made and art center was completed was outside the identified ed on the plan of care for 3 ed with the potential to affect atients. (#1, 2, and 7)					
	Findings include:						
<b>ARORATORY</b>	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN005869

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K002	B. WING	<b>3</b>		01/1	2/2012	
	ROVIDER OR SUPPLIER E HOME ASSISTANCE S	BERVICES		222 W	ADDRESS, CITY, STATE, ZIP CODE WAYNE ST WAYNE, IN 46802	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
G 158	certification period 6. dated 7/29/11 was not twice a day. There was second visits was man Second visits began 8/10. No second visit	contained a plan of care for (28/11 - 8/28/11. An order of the detail of the content of the detail of the content of the conte	G	158				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
	15K002	B. WING		01/1	2/2012
NAME OF PROVIDER OR SUPPLIER  SUNSHINE HOME ASSISTANCE SE	ERVICES	2	REET ADDRESS, CITY, STATE, ZIP CODE 22 W WAYNE ST FORT WAYNE, IN 46802		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
12/3/11 and timed 4:3 reading of 136/96 with heart center had been  E. The skilled nur 12/12/11 and timed 5: reading of 149/93 with heart center had been  F. The skilled nur 12/21/11 and timed 6: reading of 155/95 with heart center had been  4. On 1/12/11 at 2:30 indicated the nurses a party per orders them office to notify that resof BP out of paramete 484.18(a) PLAN OF COME The plan of care deversincluding mental status equipment required, find prognosis, rehabilitation limitations, activities prequirements, medical safety measures to prognosity in the status of the system of the s	ursing report sheet for 80-5:00 PM visit noted a BP in no documentation the in notified as ordered.  It is is is in the interest of the interest of it is interest.  It is is in the interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest of it is interest.  It is interest of it is interest of it is interest of it is interest.  It is interest of it is interest of it is interest of it is interest.  It is interest of it is interest of it is interest of it is interest.  It is interest of it is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is interest.  It is interest of it is interest of it is interest.  It is interest of it is	G 158			3/2/12

		(X3) DATE SUF COMPLET	COMPLETED				
		15K002	B. WIN	IG_	<del> </del>	01/1	2/2012
	ROVIDER OR SUPPLIER E HOME ASSISTANCE S	ERVICES		2	REET ADDRESS, CITY, STATE, ZIP CODE 222 W WAYNE ST FORT WAYNE, IN 46802	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 159	and the plan of care of certification period an 10 of 10 records with agency's 57 patients.  Findings include:  1. Clinical record #1 the certification period be ended on 8/26/11.  2. Clinical record #2 the certification period be ended on 8/27/11.  3. Clinical record #3 one certification period be ended on 8/27/11.  3. Clinical record #3 one certification period another certification period another certification period another certification period another certification period have ended on 12/31 period would have be 4. Clinical record #4 the certification period would have be 4. Clinical record #4 the certification period have ended on 1/26/25. On 1/11/12 at 10 /4 patient #5 had an ele hospital bed, and life The plan of care for the 12/1/11 - 2/1/12 failed equipment. The certification the certification that the plan of care for the certification that the plan of care for the plan of the certification that the plan of the certification that the plan of the plan of the certification that the plan of	dates were for a 60 day d dates did not overlap for the potential to affect all the (#1 - 10)  contained a plan of care for d 6/28/11 - 8/28/11. The ginning 6/28/11 should have  contained a plan of care for d 6/29/11 - 8/29/11. The ginning 6/29/11 should have  contained 2 plans of care, d dated 11/2/11 - 1/2/12 and deriod dated 1/2/12 - 3/2/12. In deginning 11/2/11 would deriod dated 1/2/12 - 2/29/12.  contained a plan of care for d dated 11/28/11 - 1/28/12. In deginning 11/28/11 should 12.  AM, a home visit identified ctric wheelchair, Hoyer lift, alert button in the home.	G	159			

	DEFICIENCIES CORRECTION						
		15K002	B. WIN	IG_	<del> </del>	01/1	2/2012
	OVIDER OR SUPPLIER  E HOME ASSISTANCE S	ERVICES	<b>.</b>	2	REET ADDRESS, CITY, STATE, ZIP CODE 222 W WAYNE ST FORT WAYNE, IN 46802		
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G 159	the certification period certification period be have ended on 12/29.  7. Clinical record #7 the certification period another one from 1/1 certification period be have ended on 1/9/12 period would have be 8. Clinical record #8 the certification period be have ended on 1/20/19. Clinical record #9 the certification period certification period certification period shave ended on 1/20/19. Clinical record #9 the certification period certification period shave ended on 1/12/12 at 9:3 identified patient #10 life line button, and share for the certification failed to evidence the The record contact dated 10/29/11 - 12/2 - 2/29/12. The certification period 12/29/11 would have next certification period 12/28/11 - 2/25/12.	d 10/30/11 - 12/30/11. The ginning 10/30/11 should /11.  contained a plan of care for d 11/11/11 - 1/11/12 and 1/12 - 3/11/12. The ginning 11/11/11 should d and the next certification en from 1/10/12 to 3/9/12.  contained a plan of care for d 11/22/11 - 1/22/12. The ginning 11/22/11 should 2.  contained a plan of care for d 11/18/11 - 1/18/12. The ould have been to 1/16/12.  do AM, a home visit had an electric wheelchair, hower chair. The plan of on period 12/29/11 - 2/29/12 se pieces of equipment.  ined 2 plans of care, one 9/11 and one dated 12/29/11 eation period beginning ended on 12/27/11 and the od would have been from		159			
G 170		illed nursing services in	G	170			3/2/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K002	B. WIN	G		01/1:	2/2012
	ROVIDER OR SUPPLIER  E HOME ASSISTANCE S	ERVICES	•	222	EET ADDRESS, CITY, STATE, ZIP CODE 2 W WAYNE ST ORT WAYNE, IN 46802		
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G 170	Based on clinical recthe agency failed to enheart center occurred pressure was outside and as ordered on the records reviewed with the agency's 57 patients.  Findings include:  1. Clinical record #7 certification period do orders to contact heap pressure (BP) over 10 pressure over 90. Ar indicated that these pafternoon and evening.  A. The skilled nutled 11/11/11 and timed 42 readings of 146/96 and documentation the heap ordered.  B. The skilled nutled 11/13/11 and timed 44 reading of 130/100 wheart center had been contact the pressure over 90. Ar indicated that these pafternoon and evening 11/13/11 and timed 44 readings of 146/96 and documentation the heap ordered.  C. The skilled nutled 11/20/11 and timed 34 reading of 151/100 wheart center had been contact the pressure over 90. The skilled nutled 12/3/11 and timed 4:30 reading of 151/100 wheart center had been contact the pressure over 90.	not met as evidenced by: ord review and interview, ensure notification to the diwhen the patient's blood of the identified parameters e plan of care for 1 of 10 in the potential to affect all ints. (#7)  included a plan of care for ited 11/11/11-1/11/12 with rt center if systolic blood of and/or diastolic blood order dated 11/12/11 earameters applied to g visits only.  rsing report sheet for 30-5:30 PM visit noted 2 BP ind 108/100 with no eart center had been notified  rsing report sheet for iso-5:00 PM visit noted a BP ith no documentation the in notified as ordered.	G	170			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K002	B. WIN	G		01/1:	2/2012
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G 170	12/12/11 and timed 5 reading of 149/93 with heart center had been F. The skilled nu 12/21/11 and timed 6 reading of 155/95 with heart center had been 2. On 1/12/11 at 2:30 indicated the nurses aparty per orders them office to notify that resof BP out of paramete 484.36(c)(2) ASSIGN HOME HEALTH AIDE The home health aide ordered by the physical that the aide is permission.  This STANDARD is a Based on clinical records reviewed of phealth aide services with the side services with	rising report sheet for 1:15-5:45 PM visit noted a BP h no documentation the notified as ordered.  rsing report sheet for 1:00-6:30 PM visit noted a BP h no documentation the notified as ordered.  PM, the Director of Nursing are to call the responsible party was notified ers ordered.  IMENT & DUTIES OF E e provides services that are cian in the plan of care and tted to perform under state  and met as evidenced by: cord review and interview, ensure the aide provided the aide plan of care for 4 of 8 patients receiving home with the potential to affect all at that received home health		225			3/2/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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G 225	care plan for the cert 8/28/11 that identified nail care and mouth. The aide was also to The personal care for 7/1/11 failed to evide nail care. The flow so "Linen Change/Straig marked for every day determined when or A. The persona of 7/5 - 7/9/11 failed received any nail car section labeled "Line which had been mar unable to be determined when or B. The personal of 7/11 - 7/15/11 failed received any nail car section labeled "Line which had been mar unable to be determined to be determined to be determined any nail car section labeled "Line which had been mar unable to be determined to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line which had been mar unable to be determined any nail car section labeled "Line	included a home health aide ification period 6/28/11 to d the patient was to receive care daily Monday - Friday. change the bed weekly. It was to the patient received any heet had a section labeled ighten Room" which had been with the linen was changed.  It care flow sheet for the week to evidence the patient e. The flow sheet had a n Change/Straighten Room" ked for every day. But it was ned when or if the linen was are flow sheet for the week to evidence the patient e. The flow sheet for the week to evided services on 7/4/11 (a went on Saturday instead.  It care flow sheet for the week to do evidence the patient e. The flow sheet had a n Change/Straighten Room" ked for every day. But it was ned when or if the linen was ned when or if the linen was ned when or if the linen Room" ked to evidence the patient e. The flow sheet for the week the do evidence the patient e. The flow sheet for the week the do evidence the patient e. The flow sheet for the week the do evidence the patient e. The flow sheet for the week the do evidence the patient e. The flow sheet had a n Change/Straighten Room" ked for every day. But it was ned when or if the linen was	G	225				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETI	
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G 225	of 7/25 - 7/29/11 failer received any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care section labeled "Line which had been mark unable to be determined any nail care any of 8/22 - 26/11 failed to received nail care any of 8/22 - 26/11 failed to received nail care any	care flow sheet for the week do to evidence the patient e. The flow sheet had a nor Change/Straighten Room" led for every day. But it was ned when or if the linen was not care flow sheet for the week of evidence the patient e. The flow sheet had a nor Change/Straighten Room" led for every day. But it was ned when or if the linen was not care flow sheet for the week to evidence the patient e. The flow sheet had a nor Change/Straighten Room" led for every day. But it was ned when or if the linen was ned when or if the linen was ned when or if the linen was not care flow sheet for the week do evidence the patient e. The flow sheet had a nor Change/Straighten Room" led for every day. But it was ned when or if the linen was ned when or	G	225			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	OVIDER OR SUPPLIER  HOME ASSISTANCE S	ERVICES	l	2	EET ADDRESS, CITY, STATE, ZIP CODE 22 W WAYNE ST ORT WAYNE, IN 46802	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 225	labeled "Linen Changhad been marked for unable to be determin changed.  2. Clinical record #2 care plan dated 7/6/1 emptied the urinary d Drainage Bag" section personal care flow sh 7/15 - 17, 7/19, 7/26 - 8/5/11 evidenced the bag.  3. Clinical record #3 quadriplegic. The per 11/3 - 4, 11/7, 11/11, 11/28, 12/5, 12/7, 12/1 evidenced the aide has ambulation."  4. Clinical record #4 health aide care plan that identified fingernate done by the aides sheet for 12/2/11, 12/1	ge/Straighten Room" which every day. But it was ned when or if the linen was included a home health aide 1 that identified the patient rainage bag. The "Empty n was not marked. The eet for 7/5/11, 7/12 - 13, 27, 7/29 - 31, 8/2, and aide emptied the drainage identified the patient was a rsonal care flow sheet for 11/14, 11/18, 11/21, 11/25, 9, 12/17, and 12/22/11 and provided "assist with identified included a home reviewed 11/1/11 and 1/9/12 ail care was not marked to 1. The personal care flow 17 - 18/11 and 12/24/11 rovided fingernail care to the	G	225			